Navajo County
Overdose Fatality Review
Annual Report
2020

NAVAJO COUNTY
PUBLIC HEALTH SERVICES DISTRICT

Promoting Quality Health through Community Education, Planning and Partnerships

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Introduction

Background

In response to Governor Ducey's declaration of a State of Emergency (due to the Opioid Overdose Epidemic) June 5, 2017, and under the direction and with the assistance of The Arizona Department of Health Services (ADHS), Navajo County Community Public Health Services District (NCCPHSD) commenced its first Overdose Fatality Review (OFR) team meeting in January of 2020.

Data Sources

The Arizona Department of Health Services Office of Injury Prevention and Violence Prevention provides county level drug-related death data from the Database Application of Vital Events (D.A.V.E.) Under local authority, NCCPHSD collects data from the Navajo County Office of the Medical Examiner, the Navajo County Office of Vital Records, Arizona Department of Corrections, local law enforcement and emergency medical services records, behavioral health and medical records (when applicable) and family interviews. Inclusion and exclusion criteria for deaths reviewed were determined to reduce duplicative efforts and to provide the most informed reviews, based on available records.

Inclusion criteria include:

- deaths of Navajo County residents
- deaths that occurred within Arizona
- deaths with primary cause of death attributed to substances (prescribed and non-prescribed)

Exclusion criteria include:

- overdose deaths that occurred on Tribal lands
- overdose deaths where primary residence is on Tribal lands

Purpose

The purpose of the OFR is to identify system gaps and community-specific overdose prevention and intervention strategies to reduce and eliminate overdose deaths (U.S. Department of Justice, 2021).

Process of Case Reviews

1. Cases identified

2. Records requested

3. Case Summaries created

4. Cases confidentially reviewed by multidisciplinary team and recommendations made.

OFR team members:

-Sydney Fox, MPA, Public Health Analyst & Randy Moffit, Drug Intelligence Officer - Arizona High Intensity Drug Trafficking Public Health Analysist
-Kraig Muder, PHARMD -Summit Healthcare, Pharmacy Manager
-Sara Hart, LCSW -Summit Healthcare
-Paula Kaye Martin, LISAC, MS, Med -Change Point
-Christy Ross -Little Colorado Medical Center
-Local Law Enforcement and Emergency Medical Services representatives
-Wade Kartchner, MD, MPH -Navajo County Public Health Medical Director
-Larry Czarnecki, DO, & Maisie El-Ters -Coconino County Medical Examiner's Office
-Nikki Olson-Medical-Legal Death Investigator -Navajo County Medical Examiner's Office
-Amy Stradling, Alyssa Lemmon BSN, Shaelee Hensley, Mallorie Ovah, & Linda Teague PA, NCPS -Navajo County Public Health Services District

Findings and Commonalities

While reviewing data on each overdose fatality, multiple commonalities were noted to be shared among the individuals who died. These commonalities can include similar events, traits, life circumstances, health status, and more. Though not classified as causal factors, identifying commonalities among overdose fatality decedents provides insight into risk factors and highlights opportunities for intervention.

- 44% had a history of chronic pain
- 64% had at least one Behavioral/Mental Health diagnosis in their lifetime (Diagnoses include: Anxiety, Depression, Bipolar, Schizophrenia, PTSD, Personality Disorder, and Traumatic Brain Injury)
- 84% had at least one diagnosis of a chronic medical condition (see Summary of Data)
- 44% had a history of chronic alcoholism
- 60% had a history of incarceration
- 32% had experienced homelessness in their lifetime
- 76% had experienced one or more ACE. 36% had an ACE score of 4 or more, at which point, the risk for serious psychological and chronic health conditions doubles or triples.

ACEs include, but are not limited to, experiencing or witnessing violence, abuse, or neglect; having a family member die by suicide; growing up in an environment/household with substance use or mental health problems; or separation from a parent by divorce or incarceration (Centers for Disease Control and Prevention (CDC), 2021). According to research, ACEs have been linked to chronic health conditions, mental illness, and substance use in adulthood (CDC, 2021). ACEs are sometimes revealed in medical/mental health records, however, more often, the history of childhood trauma is disclosed during the family/next of kin interview. While family interviews are attempted for each decedent, 20% of the cases from 2020 were lacking this significant contribution.

Recommendations (R) & Actions Taken (A)

The Navajo County Overdose Fatality Review Team identified key prevention recommendations for each fatality reviewed. The recommendations below were the most frequently identified and were shared with a variety of community partners to improve and enhance services in Navajo County:

Improve Care Coordination/Case Management

- Among hospitals, primary care practitioners, jails, and treatment facilities
  - ✓ Increase "warm hand-off"/appropriate referrals following hospitalization/incarceration (R)
  - ✓ Establish an Overdose Crisis Response Team (R)
    - NCPHSD certified their first employee as a Peer Support Specialist (NCPS) (A)
  - ✓ Use OFR meetings to clarify practices and policies around substance use disorder treatment, referrals and naloxone (A)
  - ✓ Improve prescribing practices (R)

Increase access to care

- Appropriate mental health care
  - ✓ Include mental health into OFR meetings & align goals of connecting individuals to care and resources (A)
  - ✓ Increase youth-specific services to address ACEs (R)
- Harm reduction services
  - ✓ Train and distribute naloxone throughout the community (A)
  - ✓ Acquire and distribute Fentanyl testing strips throughout the community (A)
- Inpatient/outpatient treatment
  - ✓ Increase treatment facilities/options to include Medication Assisted Treatment (MAT) during hospitalization/incarceration and following release (R)
  - ✓ Offer resources after family interviews (A)
  - ✓ Promote use of Opioid Assistance & Referral Line (A)
  - ✓ Increase family support services (R)

Increase education (among healthcare service providers and community members)

- Stigma reduction
  - ✓ Held 1st annual International Overdose Awareness Day (August 28, 2021) (A)
  - ✓ Use Person First language (A)
- Naloxone (Narcan)
- Polysubstance use, trending street drugs
- Co-morbid conditions
  - ✓ Train staff to be Mental Health First Aid (MHFA) trainers (A)
- Safety with medication use/storage

Assist with social determinants of health

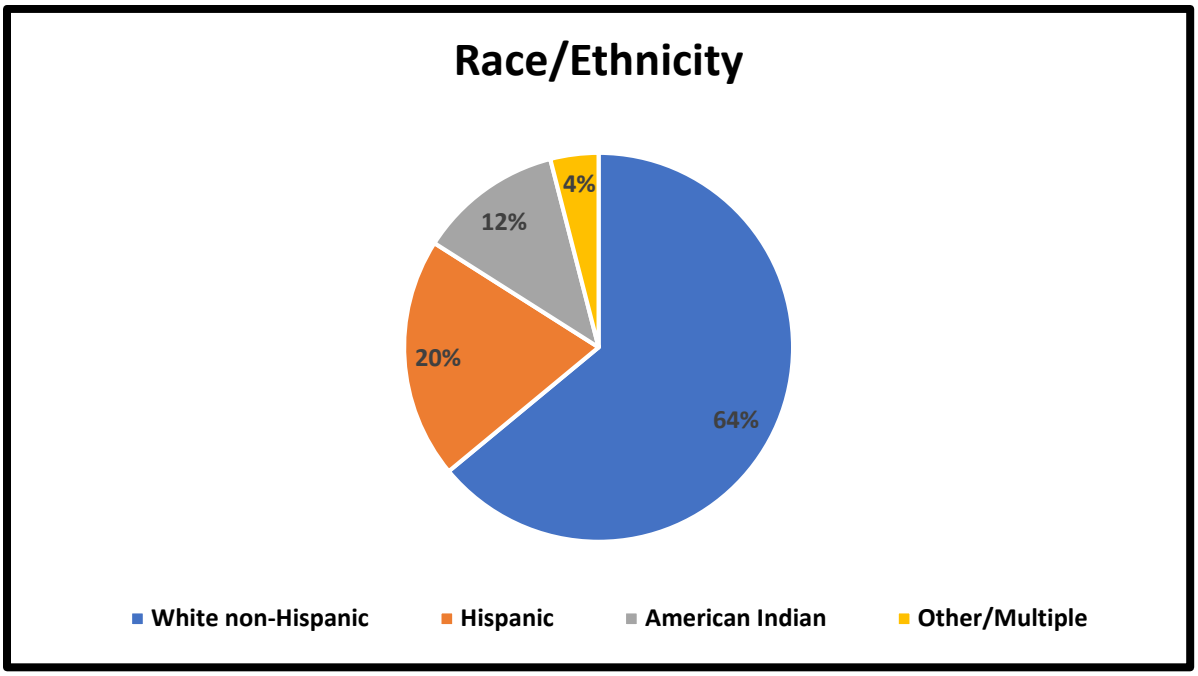
- Address Adverse Childhood Experiences in the community
- Job security and stable housing

Future Plans

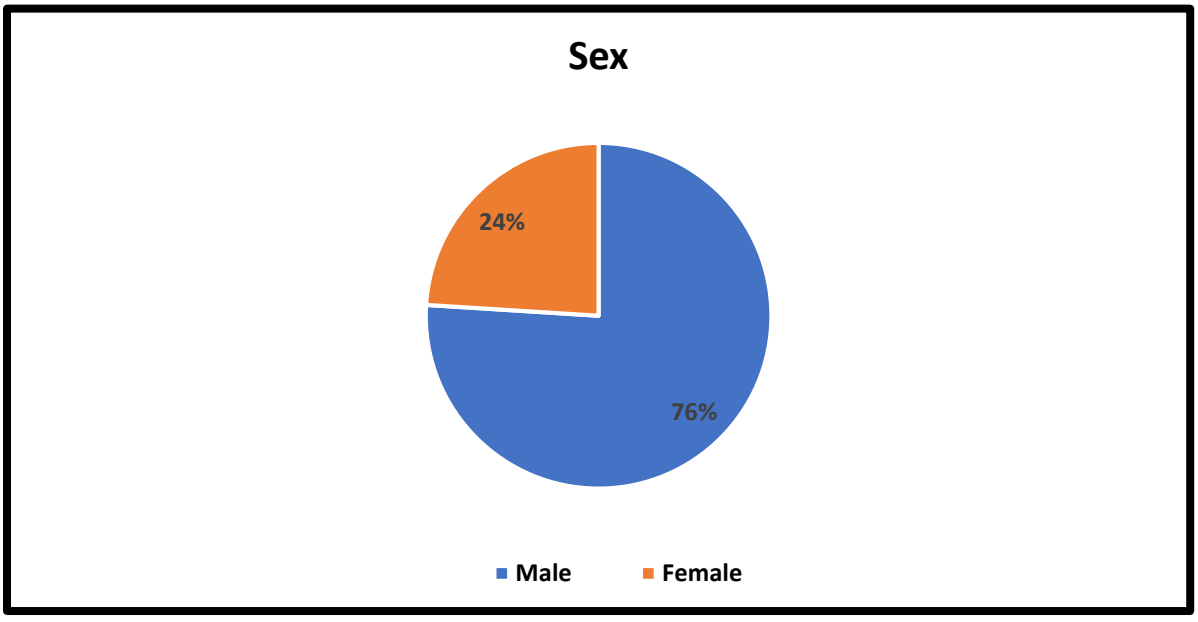
- Establish an Overdose/SUD Crisis Response Team (Improve Care Coordination/Case Management)
    - Train staff to be ACE instructors and provide community courses (Increase Education/Assist with Social Determinants of Health)
- Hire Overdose Prevention Coordinators with lived experienced trained as Peer Support Specialists (Improve Care Coordination/Case Management)
- Develop Harm Reduction strategies (Increase Access to Care)
    - Harm Reduction Advisory Council and Hotline
    - Work with correctional facilities and courts to provide Harm Reduction Services to detainees prior to release (Improve Care Coordination/Increase Access to Care)
    - Initiate a Syringe Service Exchange Program
    - Harm Reduction kiosks
- Organize Community Listening Sessions with faith-based organizations (Increase Education)
- Host 2nd Annual International Overdose Awareness Day (Increase Education)

Summary of Data

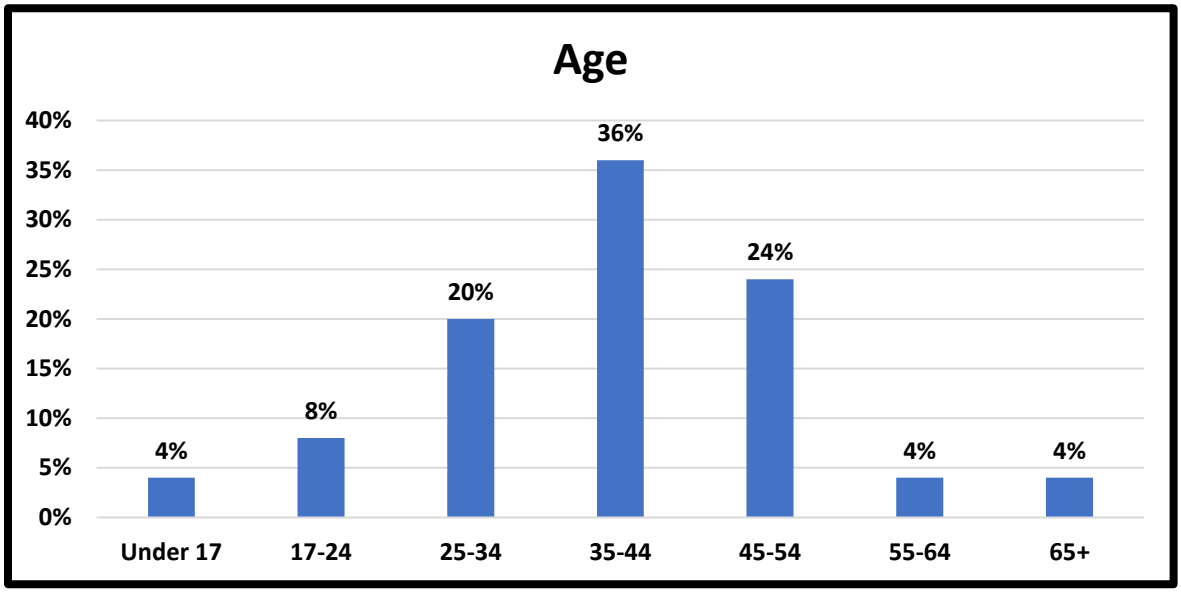
Race/Ethnicity



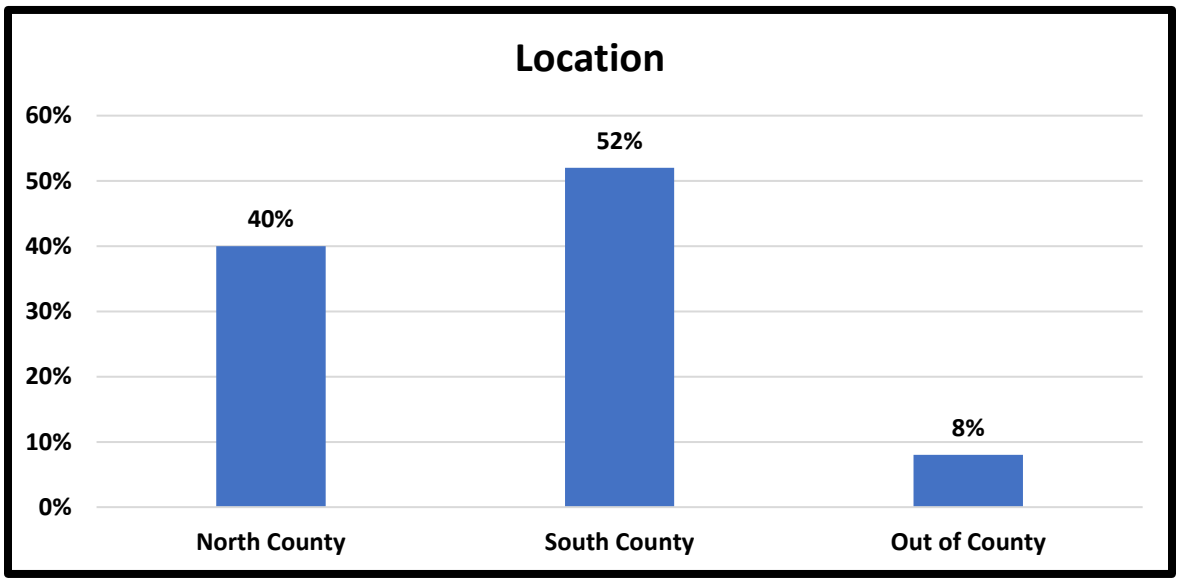
Sex



Age

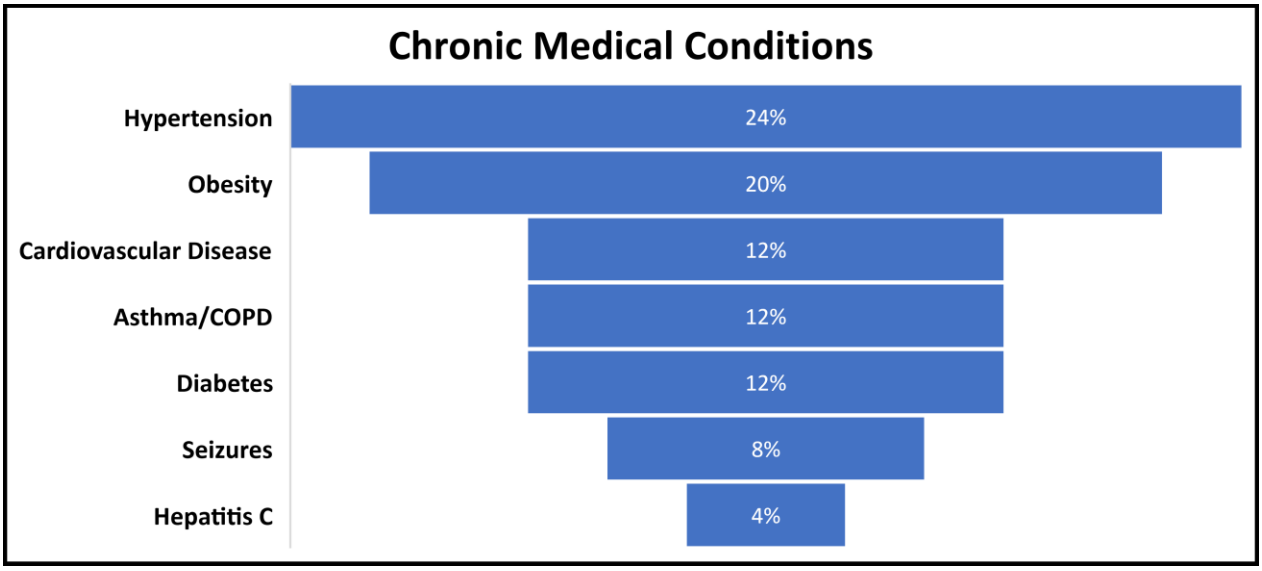


Location

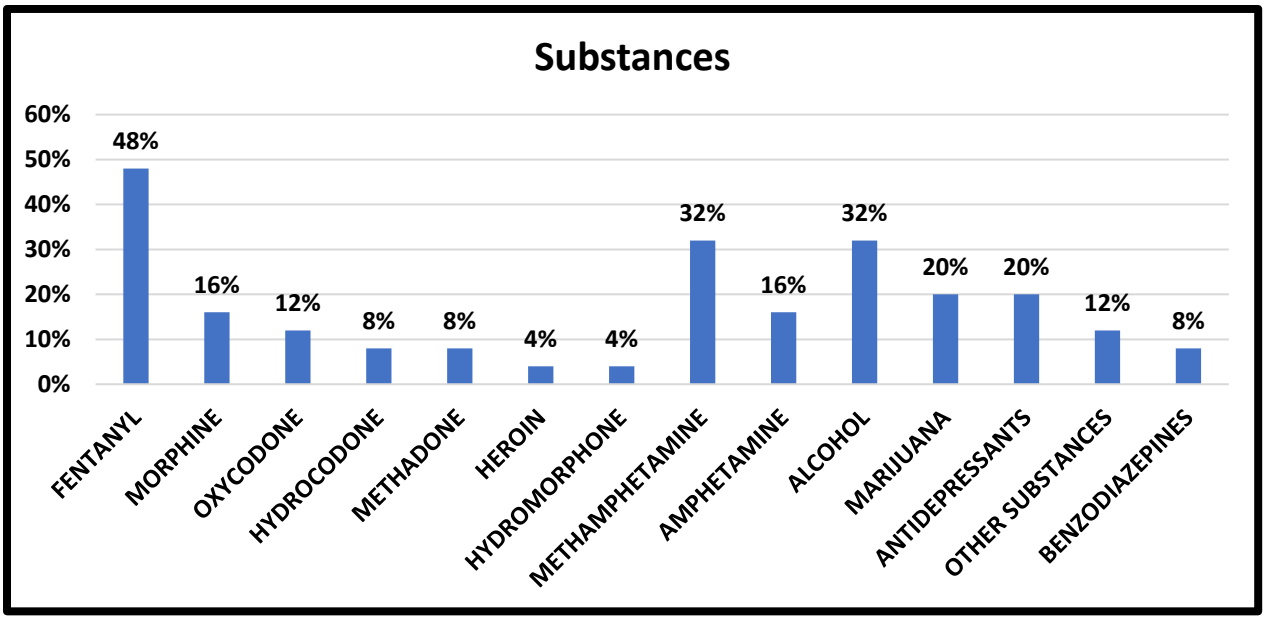


South County is defined as communities including and south of Snowflake/Taylor AZ. North County is defined as communities north of Snowflake/Taylor AZ. Overdose deaths occurring on Tribal lands are not included in this report.

Chronic Medical Conditions



Substances



[Of the overdose deaths, y % had x substance in toxicology results]

Other substances included Diphenhydramine (antihistamine) and Pregabalin (Fibromyalgia medication), and Ibuprofen (NSAID). Toxicology results indicate that any given overdose fatality could include 1 to 6 substances present at the time of death.

Conclusion

The overarching goal of the Overdose Fatality Review is to eliminate deaths related to substance use by reviewing overdose fatalities and identifying effective prevention strategies. As community stakeholders, agencies, and residents employ the evidence-based and innovative interventions, we can empower our community to contend against the opioid epidemic, save lives, and promote healing among families and individuals.

References

Centers for Disease Control and Prevention. (2021). *Preventing adverse childhood experiences.* https://www.cdc.gov/violenceprevention/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Ffastfact.html

U.S. Department of Justice, Bureau of Justice Assistance. (2021). *Overdose fatality review.* https://www.cossapresources.org/Learning/ForumOFR/About